MEDICAL HISTORY

Name______________________________Age________Wt.(if child)________Date_______________

Please state specific reason for your visit:______________________________

Please list all drug related **ALLERGIES**:______________________________

Do you smoke? ▫ YES ▫ NO Do you: ▫ dip ▫ chew? If so, how many years?_____ If you quit, when___________

Do you drink alcohol? ▫ YES ▫ NO How many drinks per day, week, month:______________________________

Do you have a history of (check the appropriate box or boxes):

General

- ▫ AIDS
- ▫ Anemia
- ▫ Asthma
- ▫ Breathing Difficulty
- ▫ Cancer
- ▫ Diabetes
- ▫ Dizziness
- ▫ Gastric Reflux
- ▫ Hepatitis
- ▫ HIV Positive
- ▫ Lung Problems
- ▫ Nasal Allergy
- ▫ Post-Nasal Drip
- ▫ Prostate Problems
- ▫ Radiation
- ▫ Sinus Infections
- ▫ Stomach Acid
- ▫ Thyroid Disorder
- ▫ Ulcers
- ▫ Urinary Disorder

Cardiovascular

- ▫ Bleeding Tendency
- ▫ Chest Pain
- ▫ High Blood Pressure
- ▫ Low Blood Pressure
- ▫ Irregular Heart Beat
- ▫ Rapid Heart Beat
- ▫ Poor Circulation
- ▫ Heart Attacks
- ▫ Cardio Vascular Surgery

Skin

- ▫ Bruise easily
- ▫ Change in Moles
- ▫ Hives
- ▫ Itching
- ▫ Keloids
- ▫ Scars
- ▫ Skin Cancer
- ▫ Sores that won't heal

Eye, Ear, Nose, Throat

- ▫ Allergies
- ▫ Bleeding Gums
- ▫ Blurred Vision
- ▫ Earache
- ▫ Cough
- ▫ Difficulty Swallowing
- ▫ Ear Discharge
- ▫ Gagging
- ▫ Hay Fever
- ▫ Ear Itching
- ▫ Hoarseness
- ▫ Loss of Hearing
- ▫ Nasal Obstruction
- ▫ Neck Masses
- ▫ Neck Pain
- ▫ Nosebleeds
- ▫ Oral Lesions
- ▫ Puffy Eyelids
- ▫ Ringing in Ears/Tinnitus
- ▫ Shortness of Breath
- ▫ Sinus Drainage
- ▫ Sinus Headaches
- ▫ Skin Lesions
- ▫ Sneezing
- ▫ Snoring
- ▫ Sore Throat
- ▫ Watery Eyes
- ▫ Voice Changes

List all medications you are currently taking **along with the dosage** (Including over the counter) : (Please use reverse side if necessary):______________________________

List all previous operations, hospitalizations, or major illnesses along with approximate date: (Please use reverse side is necessary) ______________________________

Have you ever had a reaction to anesthetics? ▫ YES ▫ NO (If yes, please explain on reverse)

Do you wear hearing aids? ▫ YES ▫ NO ▫ Left ▫ Right ▫ Both

When and where was your last hearing test? ______________________________

Family History (Includes brothers, sisters, parents and grandparents ***only***)

Heart Disease ▫ YES ▫ NO Diabetes ▫ YES ▫ NO ▫ Other____________________

Cancer ▫ YES ▫ NO Bleeding Disorder ▫ YES ▫ NO ____________________

____
Signature of Patient/Responsible Party

____
Physician Signature